		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027581

Facility Name: Manorcare at Champaign

Address: 309 E. Springfield (Number) Champaign (City) 61820 (Zip Code)

County: Champaign

Telephone Number: (217) 352-5135 **Fax #** (217) 352-9139

IDPA ID Number: 520886946008

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/03 to 05/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice-President Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,332	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,332	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,366	1,292	7,025	9,683	8
9	SNF/PED					9
10	ICF	9,310	14,140	441	23,891	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,676	15,432	7,466	33,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.93%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 6,534

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/04 Fiscal Year: 05/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	205,002	12,087	16,262	233,351	1,558	234,909		234,909			1
2	Food Purchase		147,281		147,281		147,281	(3,087)	144,194			2
3	Housekeeping	113,860	18,790	2,244	134,894		134,894		134,894			3
4	Laundry	33,225	16,998	4,728	54,951		54,951		54,951			4
5	Heat and Other Utilities			114,040	114,040	5,678	119,718	(7,483)	112,235			5
6	Maintenance	31,000	32,731	57,706	121,437		121,437		121,437			6
7	Other (specify):* Med Waste			1,138	1,138		1,138		1,138			7
8	**TOTAL General Services**	383,087	227,887	196,118	807,092	7,236	814,328	(10,570)	803,758			8
	B. Health Care and Programs											
9	Medical Director			10,325	10,325		10,325		10,325			9
10	Nursing and Medical Records	1,555,346	145,000	27,499	1,727,845	33,495	1,761,340	(6,779)	1,754,561			10
10a	Therapy	255,461	5,983	13,716	275,160		275,160		275,160			10a
11	Activities	112,056	15,921	4,380	132,357		132,357	(24)	132,333			11
12	Social Services	64,449	425	1,464	66,338		66,338		66,338			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,987,312	167,329	57,384	2,212,025	33,495	2,245,520	(6,803)	2,238,717			16
	C. General Administration											
17	Administrative	60,550		310,175	370,725	(136,283)	234,442		234,442			17
18	Directors Fees											18
19	Professional Services			1,121	1,121	(1,121)						19
20	Dues, Fees, Subscriptions & Promotions			61,380	61,380		61,380	(27,649)	33,731			20
21	Clerical & General Office Expenses	150,497	37,584	100,713	288,794	1,121	289,915	(26,652)	263,263			21
22	Employee Benefits & Payroll Taxes			530,339	530,339	37,783	568,122		568,122			22
23	Inservice Training & Education			15,186	15,186		15,186		15,186			23
24	Travel and Seminar			13,564	13,564		13,564		13,564			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,185	110,185		110,185		110,185			26
27	Other (specify):*			191	191		191	(191)				27
28	**TOTAL General Administration**	211,047	37,584	1,142,854	1,391,485	(98,500)	1,292,985	(54,492)	1,238,493			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,581,446	432,800	1,396,356	4,410,602	(57,769)	4,352,833	(71,865)	4,280,968			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Champaign #0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			269,777	269,777	20,474	290,251		290,251			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,319	83,319	37,295	120,614	(10)	120,604			32
33	Real Estate Taxes			45,094	45,094		45,094	1,175	46,269			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,611	14,611		14,611		14,611			35
36	Other (specify):*											36
37	**TOTAL Ownership**			412,801	412,801	57,769	470,570	1,165	471,735			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		200,331	28,755	229,086		229,086	(125)	228,961			39
40	Barber and Beauty Shops			18,343	18,343		18,343		18,343			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,998	55,998		55,998		55,998			42
43	Other (specify):*		41,748		41,748		41,748		41,748			43
44	**TOTAL Special Cost Centers**		242,079	103,096	345,175		345,175	(125)	345,050			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,581,446	674,879	1,912,253	5,168,578		5,168,578	(70,825)	5,097,753			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,505)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,483)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,190)	21		13
14	Non-Care Related Interest	(10)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(191)	27		16
17	Non-Care Related Fees	(58)	21		17
18	Fines and Penalties	(3,640)	21		18
19	Entertainment				19
20	Contributions	(3,114)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,575)	21		24
25	Fund Raising, Advertising and Promotional	(26,211)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,175	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Pg5A	(10,023)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,825)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (70,825)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Champaign

ID# 0027581

Report Period Beginning: 06/01/03

Ending: 05/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medical Transportation	$ (6,779)	10	1
2	Activity Income	(24)	11	2
3	P/S - Podiatry	(125)	39	3
4	Vending Revenue	(1,582)	2	4
5	Assoc Dues	(1,438)	20	5
6	Cust Reimburse	(75)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,023)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Champaign # 0027581 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,087)	0	0	0	0	0	0	0	0	0	0	(3,087)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(7,483)	0	0	0	0	0	0	0	0	0	0	(7,483)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,570)	0	0	0	0	0	0	0	0	0	0	(10,570)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,779)	0	0	0	0	0	0	0	0	0	0	(6,779)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(24)	0	0	0	0	0	0	0	0	0	0	(24)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(6,803)	0	0	0	0	0	0	0	0	0	0	(6,803)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,649)	0	0	0	0	0	0	0	0	0	0	(27,649)	20
21	Clerical & General Office Expenses	(26,652)	0	0	0	0	0	0	0	0	0	0	(26,652)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(191)	0	0	0	0	0	0	0	0	0	0	(191)	27
28	**TOTAL General Administration**	(54,492)	0	0	0	0	0	0	0	0	0	0	(54,492)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,865)	0	0	0	0	0	0	0	0	0	0	(71,865)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Champaign # 0027581 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10)	0	0	0	0	0	0	0	0	0	0	(10)	32
33	Real Estate Taxes	1,175	0	0	0	0	0	0	0	0	0	0	1,175	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,165	0	0	0	0	0	0	0	0	0	0	1,165	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(125)	0	0	0	0	0	0	0	0	0	0	(125)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(125)	0	0	0	0	0	0	0	0	0	0	(125)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,825)	0	0	0	0	0	0	0	0	0	0	(70,825)	45

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation				
Manor Care, Inc.		of America	Toledo,OH			
		(See H.O Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 310,175	HCR Manor Care,Inc.	100.00%	$ 310,175	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	11,112	Heartland Management Services	100.00%	11,112		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 321,287			$ 321,287	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH. 43604
Phone Number: (419)252-5500
Fax Number: (419)254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	$ 0	$	4,740,758	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	940,169	509,589	4,740,758	1,558	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	288,728		4,740,758	570	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	3,082,391		4,740,758	5,108	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	11,758,547	7,451,541	4,740,758	23,198	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	6,213,377	3,630,890	4,740,758	10,297	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	17,137,345	15,146,077	4,740,758	33,810	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	84,524,208	36,356,102	4,740,758	140,081	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.	4,283,731		4,740,758	8,451	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	17,698,741		4,740,758	29,332	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs. Fac.			4,740,758	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs. Fac.	12,354,014		4,740,758	20,474	12
13										13
14	32	Interest				11,412,188			37,295	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,693,439	$ 63,094,199		$ 310,175	25

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 522,057	$ 522,057			$ 37,295	1
2	City of Champaign						624,211	626,658			52,966	2
3	National City Bank, Trustee						280,211	280,211			17,585	3
4	City of Champaign - Debt Discount						(194,351)	(176,293)			12,758	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,232,128	$ 1,252,633			$ 120,604	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,232,128	$ 1,252,633			$ 120,604	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	43,919	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,094	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,175	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,094	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,269	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	42,028	8
	2000	39,962	9
	2001	40,949	10
	2002	42,434	11
	2003	45,094	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Champaign COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0027581

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	46-21-18-103-003	See Attached	$ 19,412.58	$ 19,412.58
2.	46-21-18-103-011	See Attached	$ 708.10	$ 708.10
3.	46-21-18-103-012	See Attached	$ 1,227.88	$ 1,227.88
4.	46-21-18-103-020	See Attached	$ 881.09	$ 881.09
5.	46-21-18-103-021	See Attached	$ 930.48	$ 930.48
6.	46-21-18-103-003	See Attached	$ 19,412.58	$ 19,412.58
7.	46-21-18-103-011	See Attached	$ 708.10	$ 708.10
8.	46-21-18-103-012	See Attached	$ 1,227.88	$ 1,227.88
9.	46-21-18-103-020	See Attached	$ 881.09	$ 881.09
10.	46-21-18-103-021	See Attached	$ 930.48	$ 930.48
		TOTALS	$ 46,320.26	$ 46,320.26

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,745 B. General Construction Type: Exterior Masonary Frame Steel, Fire Resistant Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1968	$ 54,050	1
2					2
3	TOTALS			$ 54,050	3

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102			1968	$ 1,201,229	$ 49,910		$ 49,910	$	$ 1,389,912	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)			1985	3,107	136,477		136,477		1,215,643	9
10				1986	8,851						10
11				1987	74,516						11
12				1987	(55,068)						12
13				1988	41,139						13
14				1989	1,297						14
15				1990	20,319						15
16				1991	50,575						16
17				1992	374,174						17
18				1992	(6,784)						18
19	RETIREMENTS			1993	51,354						19
20				1994	48,400						20
21				1995	229,982						21
22				1996	17,102						22
23	ELECTRICAL WORK			1996	10,548						23
24	WALLVINYL			1996	14,858						24
25	VINYL FLOORING			1996	1,453						25
26	INSTALL CAMERA SYSTEM			1996	35,665						26
27	REMODEL 13 ROOMS AND LOBBY			1996	21,101						27
28	HVAC			1996	1,365						28
29	ROOF WORK			1996	7,272						29
30	CORPORATE OVERHEAD-13 ROOMS/LOBBY			1996	3,880						30
31	CONCRETE WORK			1996	5,900						31
32	CARPET			1996	1,915						32
33	DIGITAL KEYPAD			1996	44,791						33
34	INSTALL EMERGENCY GENERATOR			1996	3,289						34
35	INSTALL CIRCUIT BREAKER			1996	1,867						35
36	HVAC										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL COVE BASE/SIGNS	1996	$ 2,612	$		$	$	$	37
38	C/R 5/31/99 AUDIT ADJ. - CAPITAL LABOR	1996	(7,272)						38
39	WALLCOVERINGS	1997	12,165						39
40	CARPET	1997	1,639						40
41	INSTALL HYDROLIC CYLINDER	1997	14,249						41
42	UNIT PROTECTION SWITCH	1997	6,354						42
43	FURNISH/INSTALL TILES	1997	16,476						43
44	HANDRAILS	1997	5,661						44
45	PLUMBING	1997	7,610						45
46	VINYL TILE	1997	1,643						46
47	HAND RAILS	1997	1,450						47
48	FACILITY PLAN ALLOC	1997	2,759						48
49	INSTALL GATES	1997	1,226						49
50	CORNER GUARDS	1997	314						50
51	C/R 5/31/99 AUDIT ADJ. - ALLOC. FAC. PLAN	1997	(2,758)						51
52	ELECTRICAL	1998	2,598						52
53	REPLACE WINDOWS	1998	2,763						53
54	INSTALL QUARRY TILE	1998	1,640						54
55	INSTALL DUCTWORK	1998	2,350						55
56	CORPORATE OVERHEAD	1998	1,702						56
57	SECURITY SYSTEM	1998	33,542						57
58	ENTRYWAY/PARKING LOT WORK	1998	2,209						58
59	ELEVATOR EQUP EVAL	1998	700						59
60	CARPENTRY	1998	355						60
61	WALLPAPER	1998	400						61
62	CARPETING/FLOORING	1998	2,471						62
63	PLUMBING	1998	9,690						63
64	ELECTRICAL	1998	1,367						64
65	HVAC	1998	565						65
66	PAINTING/WALLCOVERING	1998	10,552						66
67	GENERAL REQ	1998	1,500						67
68	CONTRACTORS	1998	2,507						68
69	ROOFING	1998	500						69
70	TOTAL (lines 4 thru 69)		$ 2,355,636	$ 186,387		$ 186,387	$	$ 2,605,555	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,355,636	$ 186,387		$ 186,387	$	$ 2,605,555	1
2	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1998	(1,702)						2
3	DOOR/WINDOW	1998	2,456						3
4	ELEVATORS	1998	3,433						4
5	SIGNAGE	1998	11,862						5
6	CARPETING	1999	5,993						6
7	CALL LIGHT SYSTEM	1999	42,342						7
8	1997 BILLING FOR CONSTRUCTION	1999	20,476						8
9	INSTALL SECURE DOOR KIT	1999	3,753						9
10	FABRIC FOR PATIENT FURNITURE	1999	121						10
11	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(121)						11
12	PLUMBING PARTS, LABOR, SHOWER RENOVATION	1999	900						12
13	FABRIC FOR PATIENT FURNITURE	1999	674						13
14	Reclass to Equipment - 7/22/04 IDPH verbal Adj.	1999	(674)						14
15	PAINT, WALLPAPER, CORRIDOR	1999	8,471						15
16	FIRE-SMOKE DAMPERS	1999	(581)						16
17	REMODEL KITCHEN RECEPTACLES	1999	4,800						17
18	NEW SHOWER BASE	1999	6,870						18
19	DISCOUNT, CAIN'S ROOFING	1999	(2,221)						19
20	CERAMIC TILE - 2 SHOWERS	1999	2,718						20
21	FIRE & SMOKE DAMPERS	1999	9,527						21
22	PROCARE 1000 NURSE CALL	1999	17,494						22
23	ZSN REPAIR	1999	1,307						23
24	DRAIN REPLACEMENT	2000	875						24
25	DRYWALL REPAIR	2000	600						25
26	CONTROL PANEL REPLACED	2000	984						26
27	WIRING FOR CAMERA SECURITY SYSTEM	2000	6,979						27
28	WALLCOVERINGS	2000	364						28
29	VINYL WALLCOVERINGS	2000	1,662						29
30	WALLCOVERING	2000	1,566						30
31	CLOSET DOORS	2000	13,140						31
32	WALLCOVERING	2000	37						32
33	WALLCOVERING - DINING RM	2000	1,769						33
34	TOTAL (lines 1 thru 33)		$ 2,521,510	$ 186,387		$ 186,387	$	$ 2,605,555	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,521,510	$ 186,387		$ 186,387	$	$ 2,605,555	1
2	WALL & FLOOR TILE - ARCADIA BATH	2000	3,780						2
3	CORNER GUARDS	2000	17						3
4	PAINTING & WALLCOVERING - CLOSET DOORS	2000	3,959						4
5	WALLCOVERING	2000	270						5
6	DEVELOPERS COST - ACTIVITY, LOUNGE RENOV	2000	4,708						6
7	C/R 5/31/03 AUDIT ADJ #1a - Developers Cost	2000	(4,708)						7
8	WALLCOVERING - ACTIVITY, LOUNGE RENOV	2000	6,102						8
9	VCT	2000	3,230						9
10	WIRING - ACTIVITY & REC RM	2000	1,412						10
11	ACTIV LOUNGE & BEAUTY SHOP REN	2000	1,520						11
12	PAINTING CLOSET DOORS	2000	8,000						12
13	SINK, FAUCET & PLUMBING	2000	1,985						13
14	ARCADIA HALL BATH	2000	3,933						14
15	CREDIT ON WALLCOVERING V#2072	2000	(1,566)						15
16	CLOSET DOORS	2000	7,640						16
17	SHOWER-CERAMIC TILE	2000	302						17
18	CLOSET DOOR - RETAINAGE	2000	1,460						18
19	ADDTL COST CERAMIC TILE - 2 SHOWERS	2001	203						19
20	2 NURSE STATIONS	2001	12,826						20
21	BORDER	2001	210						21
22	VCT	2001	1,130						22
23	GLASS DOORS (MAIN ENTRANCE)	2001	1,305						23
24	DOORS	2001	8,985						24
25	CARPET	2001	1,053						25
26	CEILING TILE	2001	28,650						26
27	SHOWER RENOVATION	2001	13,048						27
28	PAINTING	2001	765						28
29	COURTYARD RENOVATIONS	2001	4,775						29
30	COURTYARD RENOVATIONS	2001	5,120						30
31	DOORS	2002	746						31
32	CARPET	2002	995						32
33	WALL TILE FOR SHOWER	2002	1,840						33
34	TOTAL (lines 1 thru 33)		$ 2,645,205	$ 186,387		$ 186,387	$	$ 2,605,555	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,645,205	$ 186,387		$ 186,387	$	$ 2,605,555	1
2	MILLWORK, ELECTRICAL	2002	14,351						2
3	CARPET	2002	1,686						3
4	Freight on Carpet	2002	73						4
5	VWC	2002	282						5
6	3 Heavy Duty Doors	2002	3,574						6
7	C/R 5/31/03 AUDIT ADJ #1b - Overhead & Interest	2002	(5,444)						7
8	Painting, VWC, and Flooring	2002	1,098						8
9	Painting, VWC, and Flooring	2002	524						9
10	Renovation - Electrical 5/31/03 Audit Adj #2a Change Year	2002	87,505						10
11	Arch Engineering Costs	2002	1,018						11
12	freight on vwc	2002	9						12
13	general construction	2002	1,169						13
14	Freight on Carpet	2002	112						14
15	Carpet	2002	1,170						15
16	border	2002	1,254						16
17	freight on vwc	2002	20						17
18	carpet	2002	953						18
19	carpet and installation	2002	16,878						19
20	VWC	2002	140						20
21	carpet	2002	953						21
22	paint, vwc, and flooring	2002	9,357						22
23	Retro Addition	2002	(231)						23
24	VWC	2003	2,980						24
25	Flooring	2003	445						25
26	Reno - Gen, fire, Doors&P Audit Adj #2b Change Yr 2001 & 2002	2003	60,845						26
27	C/R 5/31/03 AUDIT ADJ #2b - Overhead & Interest	2003	(60,845)						27
28	Renovation - 5/31/03 Audit Adj #2b Change Year 2001	2001	88,776						28
29	Renovation - 5/31/03 Audit Adj #2b Change Year 2002	2002	6,593						29
30	Arch Engineering Costs	2003	172						30
31	Arch Engineering Costs	2003	774						31
32	Carpet	2003	140						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,881,535	$ 186,387		$ 186,387	$	$ 2,605,555	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,881,535	$ 186,387		$ 186,387	$	$ 2,605,555	1
2	CARPET	2003	1,075						2
3	ELEVATORS - OVERHEAD AND INTEREST	2003	3,300						3
4	ELEVATORS CARPENTRY	2003	72,624						4
5	BORDERS	2003	127						5
6	VWC	2003	438						6
7	VWC	2003	4,080						7
8	VWC	2003	571						8
9	CARPET AND INSTALLATION	2003	4,190						9
10	SHOWER ROOM FLOORS AND WALLS	2003	6,901						10
11	SHOWER ROOM FLOORS AND WALLS	2003	289						11
12	DEVELOPERS COSTS - OVERHEAD	2004	17,971						12
13	DEVELOPERS COSTS - INTEREST	2004	1,099						13
14	CARPETING AND PADS	2004	7,249						14
15	WALLCOVERINGS	2004	46,392						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,047,842	$ 186,387		$ 186,387	$	$ 2,605,555	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 854,172	$ 83,390	$ 83,390	$		$ 527,835	71
72	Current Year Purchases	96,231						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			20,474	20,474			74
75	TOTALS	$ 950,403	$ 83,390	$ 103,864	$ 20,474		$ 527,835	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,052,295	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 290,251	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,474	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,133,390	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 14,611 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	3710 hrs	$ 94,233	75	$ 4,104	$ 2,978	3,785	$ 101,315	1
2	Licensed Speech and Language Development Therapist	10A	2793 hrs	70,948	60	3,275	195	2,853	74,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	3554 hrs	90,280	102	5,573	2,810	3,656	98,663	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				200,331		200,331	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S X-Ray,Lab	10a,39,Col.3				29,519			29,519	13
14	TOTAL			$ 255,461	237	$ 42,471	$ 206,314	10,294	$ 504,246	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Champaign # 0027581 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 905	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (31,566))	543,638		3
4	Supply Inventory (priced at)	2,429		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,751		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 549,723	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	54,050		13
14	Buildings, at Historical Cost	3,047,843		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	950,403		16
17	Accumulated Depreciation (book methods)	(3,133,390)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 918,906	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,468,629	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,780	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	261,626		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,094		32
33	Accrued Interest Payable	8,857		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	71,686		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 451,043	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	730,576		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 730,576	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,181,619	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 287,010	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,468,629	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 369,373	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 369,373	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	335,415	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 335,415	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	(417,778)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (417,778)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 287,010	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,807,186	1
2	Discounts and Allowances for all Levels	(440,653)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,366,533	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	908,381	6
7	Oxygen	1,629	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 910,010	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,582	12
13	Barber and Beauty Care	20,648	13
14	Non-Patient Meals	1,505	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	184,957	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,398	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,304	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 224,394	23
	D. Non-Operating Revenue		
24	Contributions	3,114	24
25	Interest and Other Investment Income***	(58)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,056	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc Income**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,503,993	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	807,092	31
32	Health Care	2,212,025	32
33	General Administration	1,391,485	33
	B. Capital Expense		
34	Ownership	412,801	34
	C. Ancillary Expense		
35	Special Cost Centers	345,175	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,168,578	40
41	**Income before Income Taxes (line 30 minus line 40)****	335,415	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 335,415	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,926	2,086	$ 53,066	$ 25.44	1
2	Assistant Director of Nursing	5,580	6,044	139,843	23.14	2
3	Registered Nurses	9,053	9,806	176,868	18.04	3
4	Licensed Practical Nurses	24,275	26,295	418,001	15.90	4
5	Nurse Aides & Orderlies	69,947	75,770	729,217	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,168	9,947	252,694	25.40	7
8	Rehab/Therapy Aides	246	266	2,767	10.40	8
9	Activity Director	10,278	11,166	112,056	10.04	9
10	Activity Assistants					10
11	Social Service Workers	3,873	4,148	64,449	15.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,986	20,632	205,002	9.94	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,185	31,000	14.19	17
18	Housekeepers	12,077	13,118	113,860	8.68	18
19	Laundry	2,951	3,207	33,225	10.36	19
20	Administrator	1,990	2,080	60,550	29.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,114	10,250	150,497	14.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,948	3,203	38,351	11.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	184,422	200,203	$ 2,581,446 *	$ 12.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	10,325	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,325		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Doug Harridge	Administrator	0	$ 30,275
Vicki Clark	Administrator	0	15,138
Terri Taylor	Administrator	0	5,046
Pamela Britt	Administrator	0	10,091
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,550

B. Administrative - Other

Description	Amount
Home Office Allocation	$ 310,175
TOTAL (agree to Schedule V, line 17, col. 3)	$ 310,175
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Spec. Consultant	$ 1,121
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,121

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,306
Unemployment Compensation Insurance	36,908
FICA Taxes	182,393
Employee Health Insurance	200,792
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K / SMSP Match	13,944
Other Employee Benefits	4,618
Employee Uniforms	3,511
Employee Vaccinations	1,743
Employee Appreciation	7,018
Tuition Program	1,106
Home Office Allocation	37,783
TOTAL (agree to Schedule V, line 22, col.8)	$ 568,122

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,003
Advertising: Employee Recruitment	17,992
Health Care Worker Background Check	
(Indicate # of checks performed 254.2)	6,355
Dues & Subscriptions	3,078
Association Dues	4,666
Advertising	26,166
Marketing/Lecture	75
Public Relations	45
Less: Non-Allowable Assoc. Dues	(1,438)
Less: Public Relations Expense	(45)
Non-allowable advertising	(26,166)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,731

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expense to the Home	13,564
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,564

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 06/01/03 Ending: 05/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Champaign # 0027581 **Report Period Beginning:** 06/01/03 **Ending:** 05/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,666**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes $1,438**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **45,391** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES **X** NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **55,998**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,505**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.